Flexible Spending Account Request for Reimbursement

Harford County Maryland

Dates of service must fall between 07/01/2006 - 09/15/2007

I. Participant Identification
(please print or type)

Participant Name: _____ Day Time Phone: _____

Social Security Number: _____ - ____ -_____ Email: _____

Address:_____ City: _____ State:_____ Zip:_____

II. Medical Spending Account Attach invoice – Invoice must indicate date(s) of service, description of service(s) and participants portion of the cost.

(please attach a separate sheet if more space is needed)

Date(s) of Service	**Physician or other Provider**	**Amount**
_____	_____	$_____.____
_____	_____	$_____.____
_____	_____	$_____.____
Total Medical Spending Amount Requested		$_____.____

III. Dependent Care Spending Account
(please attach a separate sheet if more space is needed)

Date(s) of Service	**Provider/Tax ID # or SS#**	**Amount**
_____ to _____	_____	$_____.___
_____ to _____	_____	$_____.___
_____ to _____	_____	$_____.___

I certify that the above listed charges have been incurred. (Note to the Participant: If a signature is not provided a receipt must be attached. The receipt must indicate dates of service.)

Signature of Provider_____ Date:_____

Total Dependent Care Amount Requested $_____.___

IV. Statement by Participant

I certify that the expenses listed above have been incurred by me and/or my eligible dependents and qualify for reimbursement. I have not and will not be reimbursed through any other health plan coverage and/or dependent care assistance plan.

_____ _____
Participant's Signature Date

Please mail or fax claim forms to:
Claims Department, HFS
164 Lakefront Drive, Hunt Valley, MD 21030
View your account information at www.hfsbenefits.com
Phone: 410.771.1331 / Toll Free: 888.460.8005
Fax: 410.771.5533 / Toll Free 888.510.4218
******PLEASE DO NOT MAIL ORIGINALS******

Explanation to Participants

Medical Flexible Spending Account

1. You must submit all covered health expenses to your and/or your spouse's health insurance carrier before you submit a claim for FSA Reimbursement. When you receive an Explanation of Benefits from your insurance carrier, you may submit the EOB for reimbursement.
2. For expenses not covered under any benefit plan, (such as eyeglasses), an itemized bill must be presented that indicates the date of service, procedure, and the amount you were responsible for.
3. A canceled check or credit card receipt is not a valid form of documentation.
4. Please remember that claim reimbursement is determined by the date of service not the date paid. Therefore, the date of service must always fall within the applicable plan year.
5. If you prepay a service, the reimbursement can be requested after the service has been incurred.
6. In general, the types of medical services that can be reimbursed by the Plan are the same types of expenses which the Internal Revenue Service would allow for the medical and dental expense deduction under Internal Revenue Code Section 213. Please refer to the Summary Plan Description for a more complete explanation of qualified expenses.
7. At any time during the plan year, you may request reimbursement for expenses that may exceed the amount that you have deposited into your flexible medical account. However, your reimbursement will not exceed your annual election. Special rules apply if you terminate employment or otherwise end participation in the Plan. (see Summary Plan Description).

Dependent Care Spending Account

1. Your dependent care provider must sign this form verifying charges incurred or you must submit a receipt from the provider for services rendered.
2. If you prepay for a service, such as a summer camp, the reimbursement can be requested after the service has been incurred.
3. You are required to provide the name, address, and tax id # or social security # of your dependent care provider when you file your income tax return.
4. You will be reimbursed up to your current contribution into the Plan. Any balance will be reimbursed as you continue to contribute to the Plan.
5. In general, the types of expenses for dependent care services which can be reimbursed by the Plan are the same types of expenses which the Internal Revenue Code would consider for the dependent care tax credit as employment-related expenses under Internal Revenue Section 21 (b)(2). Please refer to the Summary Plan Description for a more complete list of qualified expenses.